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FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. Any delay is necessary, it should be executed within 72 hours after death. This certificate should be executed within 24 hours after death. Any delay is necessary, it should be executed within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9542 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09533

1. PLACE OF DEATH e. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Montgomery								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Compton			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 			d. STREET ADDRESS 6905 Wilson Lane								
3. NAME OF DECEASED (Type or print) William Henry Baltz			4. DATE OF DEATH Month August Day 22 Year 1961								
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1945		9. AGE (In years last birthday) 16 yrs. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Washington, D. C.						
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry J. Baltz								
14. MOTHER'S MAIDEN NAME Helen Snyder			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service) No								
16. SOCIAL SECURITY NO. None			17. INFORMANT Father								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (e), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Injuries			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Ran off road at high rate of speed								
20c. TIME OF INJURY Month, Day, Year 11 a.m. 8/22/1961			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>								
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rose Bank Road			20f. (City or town) (County) (State) Compton, St. Mary's, Md.								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William D. Boyd</i>			DATE SIGNED 8/23/61								
EXAMINER'S NAME (Type) William D. Boyd M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			22b. DATE THEREOF 8/24/61								
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			22d. LOCATION (City, town, or country) (State) Suitland, Maryland								
23. FUNERAL DIRECTOR Robert A. Pumphrey			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knaus</i>								
24a. REC'D BY REGISTRAR AUG 28 '61			24c. ADDRESS Bethesda, Maryland								

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CERTIFICATE OF DEATH

Reg. Dist. No. 09534

9543

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl Binder				4. DATE OF DEATH August 2, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1961	
9. AGE (In years last birthday) 6		10. IF UNDER 1 YEAR Months 6 Days 50		11. IF UNDER 24 HRS. 50		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ----			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John Joseph Binder				14. MOTHER'S MAIDEN NAME Myrtle Cecelia Bragg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Grady Bragg, Charlotte Hall, Md.				Address Mrs. Grady Bragg, Charlotte Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 760.5 IMMEDIATE CAUSE (a) Intracranial hemorrhage? DUE TO (b) 12 hrs DUE TO (c) Interval between onset and death PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/2/61 to 8/2/61 , that I last saw the deceased alive on 8/2/61 , 19 61 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 8/2/61							
ACTUAL SIGNATURE W. H. Hattley M.D.							
PHYSICIAN'S NAME (Type) W. H. Hattley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 8/13/61							
22c. NAME OF CEMETERY OR CREMATORY St. Aloysius							
22d. LOCATION (City, town, or county) (State) Leonardtown Md							
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hattley ADDRESS Leonardtown, Md.							
24a. REC'D BY REGISTRAR Aug 21 '61							
24b. REGISTRAR'S SIGNATURE Charles J. Hattley							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by hospital or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9544

09535

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ernest		4. DATE OF DEATH Aug. 3, 19 61	
5. SEX Male		6. COLOR OR RACE Olored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1890	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randolph Briscoe		14. MOTHER'S MAIDEN NAME Mollie Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Florence Briscoe		Address Ridge, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver 153.9 DUE TO Carcinoma of Large Bowel Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 months 6-7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 61 to 3 August 61 , that (I) (we) last saw the deceased alive on 28 July 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Ernest D. Rehm		22b. DATE SIGNED Aug 61	
22c. PHYSICIAN'S NAME (Type) Ernest Rehm M.D.		22d. ADDRESS Lexington Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/61	
23c. NAME OF CEMETERY OR CREMATORY St. Peter Clavers		23d. LOCATION (City, town or county) Ridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtwn, Maryland		25a. REC'D BY REGISTRAR Aug 8 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9545						CERTIFICATE OF DEATH					
09536											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland St. Mary's b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge				c. LENGTH OF STAY IN 1b 6yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridge				d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Albert V. Chase						4. DATE OF DEATH Month August Day 25 Year 19 61					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Chase						14. MOTHER'S MAIDEN NAME Margaret Beam					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 217-26-1743		17. INFORMANT Thomas L. Chase Rt. 1 Box 30A Lexington Park, Maryland				Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 382 X IMMEDIATE CAUSE (a) Cerebral Thrombosis Cerebral Atherosclerosis Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 						INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE 2 weeks yes					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Hour a.m. 19 p.m. 		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 30, 1961 to Aug 25, 1961 that (I) (we) last saw the deceased alive on 8/25/61 and that death occurred at 3:30 AM from the causes and on the date stated above.											
22a. SIGNATURE James P. Jarboe M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS Great Mills, Maryland		22c. DATE SIGNED 8/27/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 28, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Peters Clavers		23d. LOCATION (City, town or county) Ridge, Maryland		23e. REC'D BY REGISTRAR SEP 1 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Thomas	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland						25. REGISTRAR'S SIGNATURE SEP 1 '61					

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9546 CERTIFICATE OF DEATH 10641											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Loveville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural Loveville</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Loveville</u> d. STREET ADDRESS <u></u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby boy Dickerson</u>				4. DATE OF DEATH Month Day Year <u>August 22, 19 61</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1961</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>6</u> Days <u>2</u> Hours <u>6</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>	
11. KIND OF BUSINESS OR INDUSTRY <u></u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Paul M. Dickerson</u>			
14. MOTHER'S MAIDEN NAME <u>Vincina C. Somerville</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Father</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>772.5</u> (b) <u>Prematurity + immaturity</u> Conditions, gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO <u></u>				19. INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED When at work <input type="checkbox"/> Not when at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.) <u></u>			
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				21. I certify that (I) (this hospital) attended the deceased from <u>22 Aug, 19 61</u> to <u>22 Aug, 19 61</u> , that (I) (we) last saw the deceased alive on <u>22 Aug, 19 61</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Gill M.D.</u>				22b. ADDRESS <u>Leonardtown, Maryland</u>				22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Gill M.D.</u>			
22d. ADDRESS <u>Leonardtown, Maryland</u>				22e. REC'D BY REGISTRAR DATE <u>SEP 18 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/22/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>			
23d. LOCATION (City, town or county) <u>Leonardtown, Md.</u>				23e. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>				23f. LOCATION (City, town or county) <u>Leonardtown, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>				24a. ADDRESS <u>Leonardtown, Maryland</u>				24b. DATE <u>SEP 18 '61</u>			

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Pages may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9547
CERTIFICATE OF DEATH

119558

1. PLACE OF DEATH a. COUNTY SAINT MARYS b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SAINT MARYS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY SAINT MARYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Joseph Middle Waverly Last Dove		4. DATE OF DEATH Month August Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1961
9. AGE (In years last birthday) 1 yrs. 8 Months 0 Days 0 Hours 0 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ST. MARYS COUNTY, MD	
11. BIRTH PLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK DOVE		14. MOTHER'S MAIDEN NAME LORETTA LANGLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER, FRANK DOVE, SCOTLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 056.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Perfusion cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 3 day 3 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20e. (City or town) Scotland		(County) SAINT MARYS (State) MD	
21. I certify that (I) (this hospital) attended the deceased from 8/24/61 to 8/25/61 , 1961, that (I) (we) last saw the deceased alive on 8/24/61 , 1961, and that death occurred at 2:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Julius L. LANE		22b. DATE SIGNED 8/26/61	
22c. PHYSICIAN'S NAME (Type) Julius L. LANE MD		22d. ADDRESS Leonardtown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 26 August 61	
23c. NAME OF CEMETERY OR CREMATORY St Aloysius		23d. LOCATION (City, town or county) Leonardtown, Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR AUG 31 '61	
ADDRESS Leonardtown, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

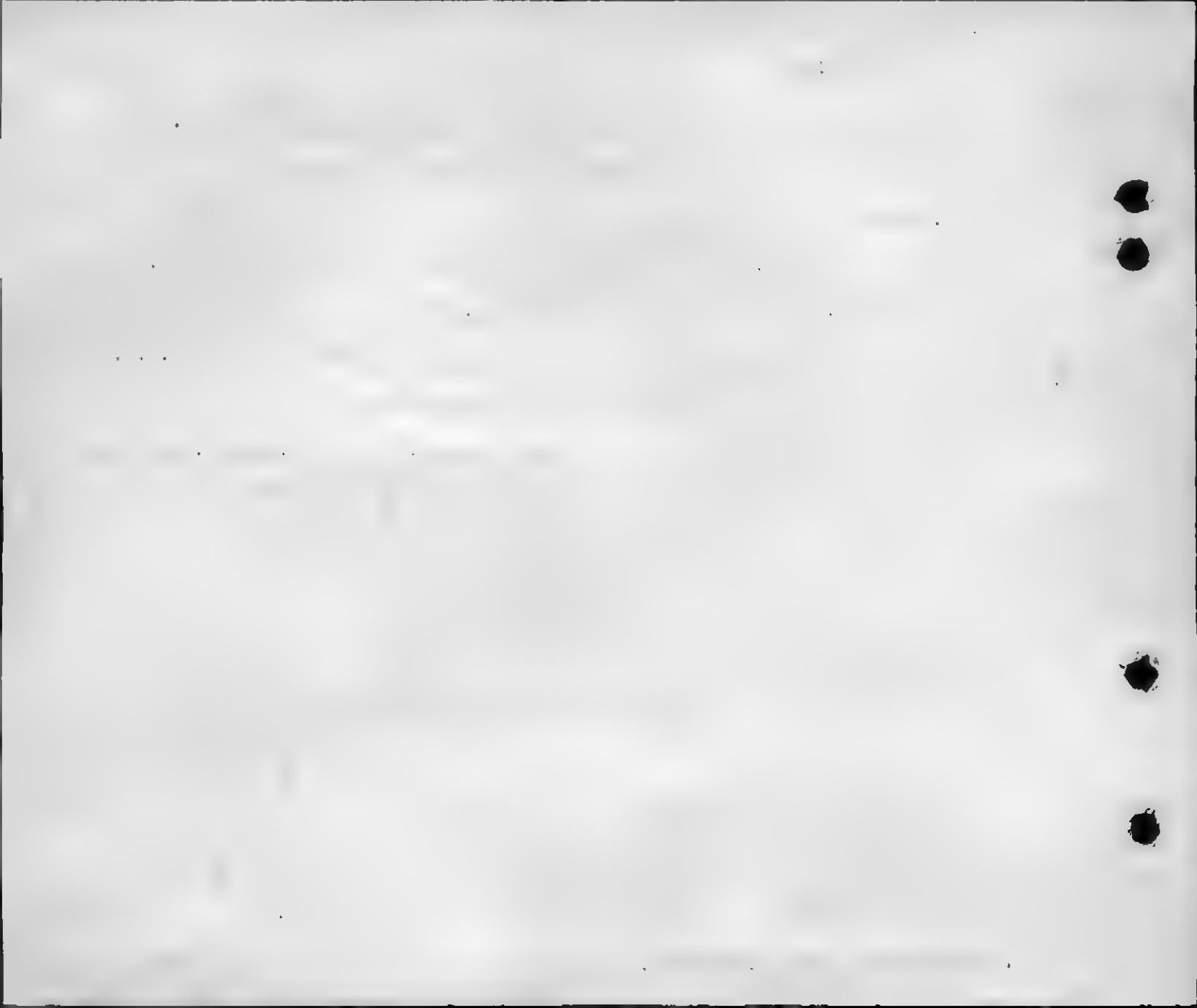
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9548

09539

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtowntown</u> c. LENGTH OF STAY IN b. <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Mary's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clements</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Noble</u> <u>Edward</u> <u>Farrell</u> First Middle Last		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 3, 1898</u> 9. AGE (In years last birthday) <u>63 yrs.</u> IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Farrell</u>		14. MOTHER'S MAIDEN NAME <u>Susie Knott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u></u>		17. INFORMANT <u>Mary Lillian Farrell</u> <u>Clements, Maryland</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>199X</u> DUE TO <u>metastatic carcinoma of abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u></u> (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>no</u> 19 <u>61</u>		20d. INJURY OCCURRED While <u>no</u> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no</u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1, 1961</u> to <u>August 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1961</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Julian S. LANE</u> 22c. PHYSICIAN'S NAME (Type) <u>Julian S. LANE</u>		22b. DATE SIGNED <u>8/21/61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>H.O. Clements, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City, town or county) <u>Bushwood,</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>AUG 24 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9549

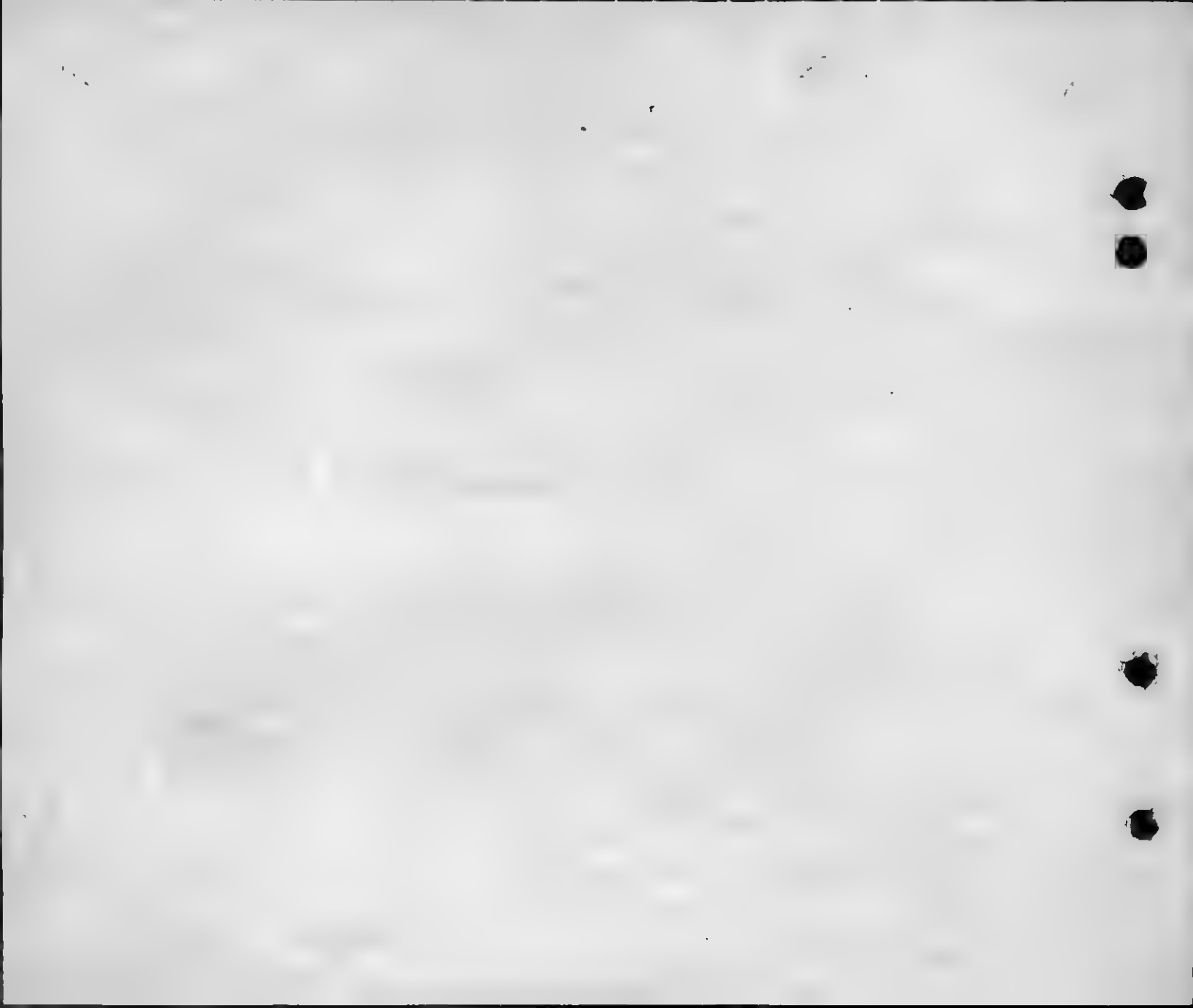
00540

1. PLACE OF DEATH a. COUNTY <u>SAINT MARY'S</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> c. LENGTH OF STAY IN 1b <u>9 hours 30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SAINT MARYS Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> (TW. N II)		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 24, 1961</u>		9. AGE (in years last birthday) <u>7</u> 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARYS County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy Holly</u>		14. MOTHER'S MAIDEN NAME <u>Agnes C. Herbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mother Agnes Herbert, Leonardtown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>8/24, 1961</u> to <u>8/24, 1961</u> , that (I) (we) last saw the deceased alive on <u>8/24, 1961</u> , and that death occurred at <u>8/24, 1961</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James P. Jarboe M.D.</u>		22b. DATE SIGNED <u>8/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James P. Jarboe M.D.</u>		22d. ADDRESS _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. Aloysius</u>		23d. LOCATION (City, town or county) <u>LEONARDTOWN</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		25. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	
25a. ADDRESS <u>Leonardtown, Md</u>		25b. DATE <u>8/24/61</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the attending physician and completed by the funeral director. After the funeral, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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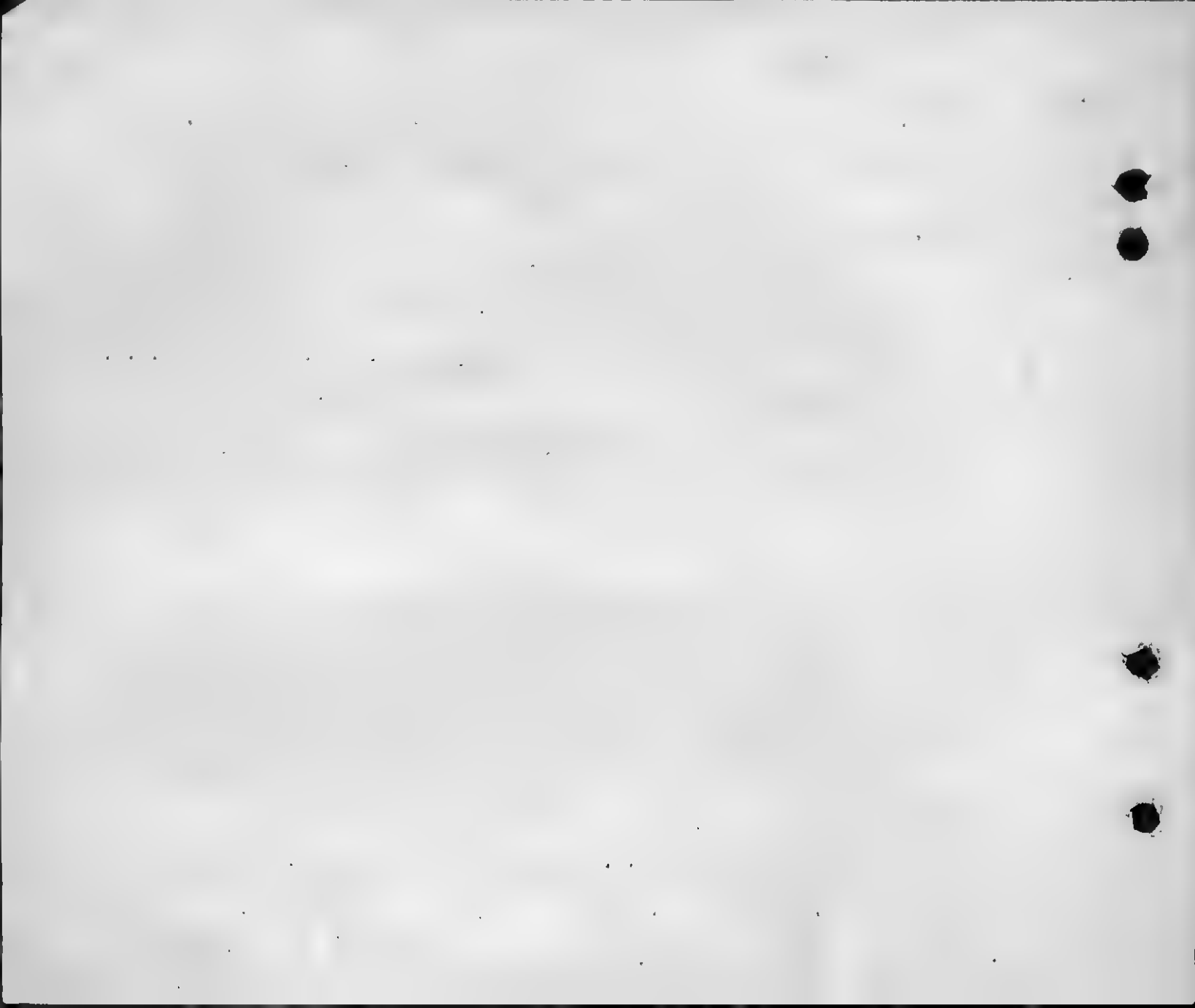
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9550
CERTIFICATE OF DEATH

113541

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Compton c. LENGTH OF STAY N 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Compton d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Derby Middle Alexander Last Lucas		4. DATE OF DEATH Month August Day 26 Year 1961			
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7 1905		9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months 5 Days 26 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Compton, Maryland	
13. FATHER'S NAME Charles Lucas		14. MOTHER'S MAIDEN NAME Helen Martin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. XXXXXX Sidney Lucas		17. INFORMANT Compton, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blood stream infection + Nephritis DUE TO (c) Heart		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/5 to Aug 26 , 19 61 , that (I) (we) last saw the deceased alive on Aug 24 , 19 61 , and that death occurred at 6AM , from the causes and on the date stated above.					
22a. SIGNATURE Charles Greenwell		22b. DATE THEREOF 8/30/61		22c. NAME OF CEMETERY OR CREMATORY St. Paul	
22d. ADDRESS Leonardtown, Maryland		22e. LOCATION (City, town or county) (State) Leonardtown, Maryland		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
22g. REGISTRAR'S SIGNATURE W. Clarke Mattingley		22h. ADDRESS Leonardtown, Maryland		22i. REGISTRAR'S SIGNATURE Arthur S. Kraus	
22j. DATE AUG 31 1961		22k. REGISTRAR'S SIGNATURE Arthur S. Kraus		22l. REGISTRAR'S SIGNATURE Arthur S. Kraus	

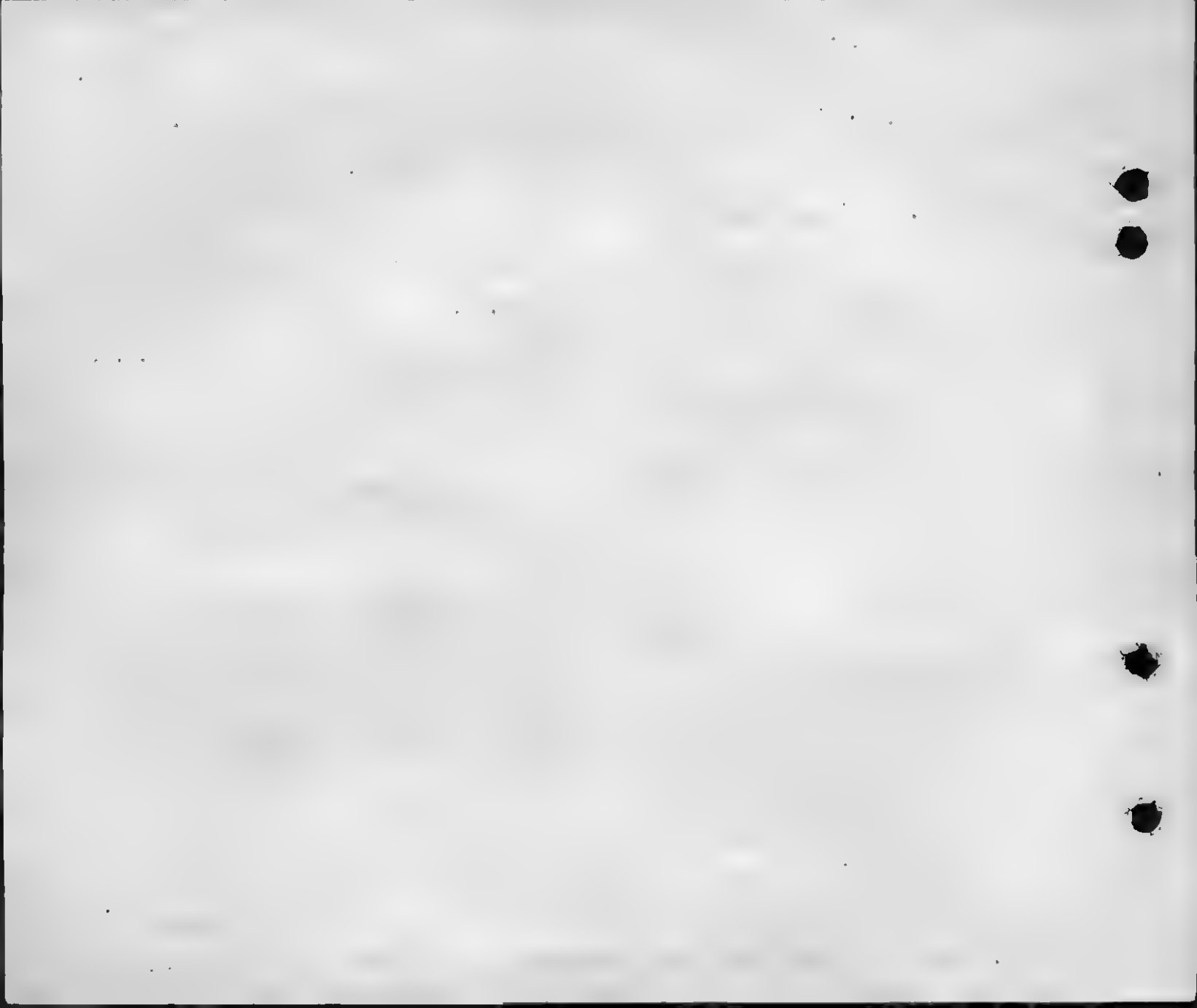
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completed by the funeral director. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
9551
M
I
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08542

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills, d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Thomas Douglas Matthews, Jr. First Middle Last 4. DATE OF DEATH August 8, 19 61 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 7, 1961 Yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Douglas Matthews		14. MOTHER'S MAIDEN NAME Julia Ann Wood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Father 17. INFORMANT Same as # 2 (If yes give war or date of service)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cranial bleeding? 760.5 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature birth			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/7 , 19 61 , to 8/8/61 , 19 61 , that (I) (we) last saw the deceased alive on 8/8/61 , 19 61 , and that death occurred at 8/8/61 , 19 61 , from the causes and on the date stated above.			
22a. SIGNATURE J. Roy		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/ 9/61	
23c. NAME OF CEMETERY OR CREMATORY Holy Face Cemetery		23d. LOCATION (City, town or county) (State) Great Mills, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR AUG 21 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Smith	



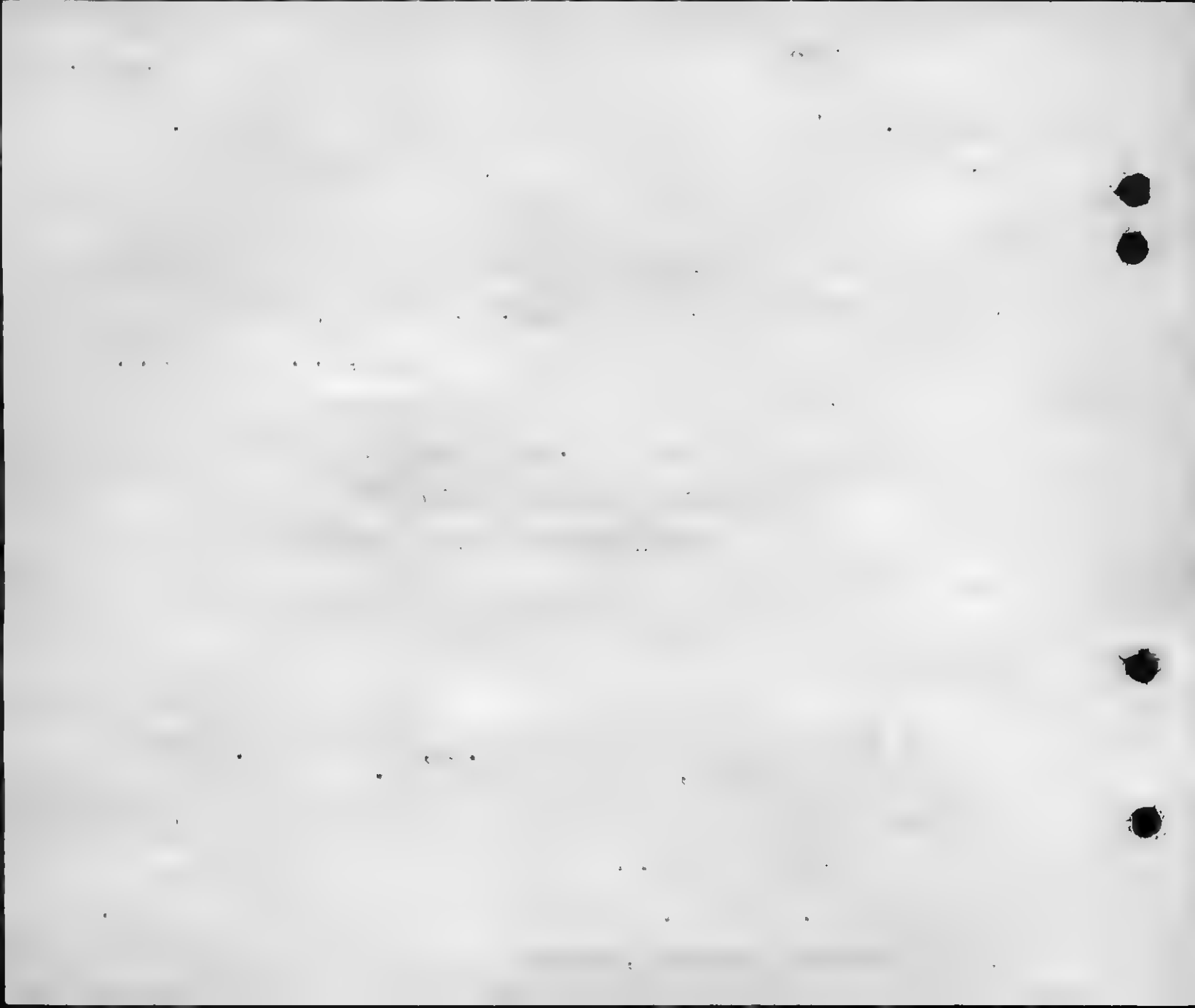
TO HOSPITAL ATTENDING MEDICAL CERTIFICATION
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9552
CERTIFICATE OF DEATH

09543

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Tall Timbers c. LENGTH OF STAY IN b 40 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Tall Timbers d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Marie Helene Meatyard		4. DATE OF DEATH Month August Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1887
9. AGE (In years last birthday) 73 yrs.		10. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME Mary Juenemann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT F. Archibald Meatyard		Address 9508 Page Ave, Alta Vista Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (Coronary) INFARCTION OF MYOCARDIUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ARTERIOSCLEROTIC CORONARY THROMBOSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 11, 1958 to AUG. 20, 1961 that (I) (we) last saw the deceased alive on AUG 20, 1961 and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell M.D.		22b. DATE SIGNED 8/21/61	
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		22d. ADDRESS Leonardtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 23, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. George Episcopal		23d. LOCATION (City, town or county) (State) Valley Lee, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR AUG 24 '61	
ADDRESS Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kinn	

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9553

CERTIFICATE OF DEATH

09544

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN b 24 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Callaway Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Nelson		4. DATE OF DEATH Aug. 2, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Nelson		14. MOTHER'S MAIDEN NAME Phylis Ann Readman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Father		Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/1/61 to 8/2/61 , that (I) (we) last saw the deceased alive on 8/1/61 and that death occurred at 8:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE James P. Jarboe M.D.		22b. DATE SIGNED 8/4/61	
22c. PHYSICIAN'S NAME (Type) James P. Jarboe M.D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/3/61	23c. NAME OF CEMETERY OR CREMATORY St. George	23d. LOCATION (City, town or county) (State) Valley Lee, Md.
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR DAING 15 '61	
ADDRESS Leonardtwn, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

VR A15 (4)
15M 9/60

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1923

(M)

(C)

(1)

(2)

Public Health

George A. Jones

Sanitary

[Handwritten signature]

West Hill

St. Louis

Miss Lee

St. Louis

Miss Lee

Miss Lee

Miss Lee, St. Louis, Mo.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9554

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09545

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Infant Girl Simmons		4. DATE OF DEATH August 2 19 61	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/61
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR 3 Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnie W. Simmons		14. MOTHER'S MAIDEN NAME Louisa Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Johnie W. Simmons - Ridge, Md.		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Bronchopneumonia, Aspiration DUE TO Brain Damage Conditions, if any, which gave rise to immediate course (c), stating the underlying cause lost. A noxia during 2nd stage of labor (b) --- (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30% Separation of Placenta		INTERVAL BETWEEN ONSET AND DEATH 1-2 days Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. --- p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) --- (County) --- (State) ---	
21. I certify that (I) (this hospital) attended the deceased from 7/29/61 to 8/2/61 , that (I) (we) last saw the deceased alive on 8/1/61 and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James P. Jarboe M.D.		22b. ADDRESS Great Mills, Md.	
22c. PHYSICIAN'S NAME (Type) James P. Jarboe, MD		22d. ADDRESS Great Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) Lexington Park, Md. (State) ---	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR --- DATE AUG 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kiana		25c. REGISTRAR'S SIGNATURE ---	

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